Application for Services for High Intensity Youth (Level of Care 5 Specialized)

The Cabinet's efforts in redesigning the out-of-home care (OOHC) system are geared toward improving outcomes for children in the Cabinet's custody. Through this request for applications, the Cabinet is seeking qualified providers who are able to meet the complex needs of children who have a need for high intensity services. The goal of this initiative is to maintain children meeting the selection criteria with one (1) provider while keeping them safe, enhancing their wellbeing, and moving them along a pathway to permanency. This request will first describe the children to be served and then identify the questions prospective applicants will need to address in their response. Service requirements outlined in this document will be in addition to those required in 922 KAR 1:300 (Standards for child-caring facilities), 922 KAR 1:310 (Standards for child-placing agencies), and the PCC agreement. Providers should anticipate that all children referred for these specialized services will be high intensity. There will be a maximum of one hundred twenty-five (125) placements statewide. Based upon successful delivery of expected service provisions, the daily rate will be two hundred fifty-seven dollars eight cents ($257.08).

Population defined:

During the redesign, research revealed that approximately one percent (1%) of children in out-of-home care fit into the category described as children needing high intensity services. These children are often difficult to place due to their aggressive behavior, sexual acting out behavior, and level of functioning. In calendar year 2009, there were one hundred seventy-three (173) children identified as needing high intensity services. Of these children, seventy-five percent (75%) had more than five (5) placement moves during the current episode of care, and all of the children had at least one (1) psychiatric hospital stay. In addition, termination of parental rights had been finalized for fifty percent (50%) of the identified group.

The high intensity population is defined as follows:

A) Children eleven (11) years of age and older who have a mental health diagnosis(es) diagnosed by a qualified mental health professional using the current edition of the Diagnostic and Statistical Manual of The American Psychiatric Association; and,

B) Who are currently exhibiting active symptoms that have persisted for more than one (1) year; or,

C) Who exhibit on a frequent basis behavior that presents an imminent risk of harm to self or others to include, but is not limited to, physical assaults requiring medical attention, self-harm that is life-threatening or results in serious physical harm, sexual behaviors that pose a threat to others, or extensive property damage; and,

D) Who exhibit at least one (1) of the following:

   a. Has had more than five (5) placement moves in the last year; or
   b. Has had more than four (4) placement moves in the last three months; or
   c. Has had more than four (4) psychiatric hospitalizations since coming into DCBS custody; or
   d. Has a unique combination of care needs as evaluated by the gatekeeper which require high intensity services.

Basic Expectations:

General Programming

The Cabinet is seeking programs in a variety of geographical areas to serve the targeted population that can provide proof of concept for required services with the goal of increased placement stability. To accomplish placement stability, the Cabinet has expectations of establishing an agreement for services with providers who are willing and able to work under a no reject/eject clause. Successful applicants will have clearly delineated acceptance criteria that will determine which children (from the population described above) are appropriate for their specific programming. The Cabinet may ask programs for further clarification regarding the acceptance criteria to ensure appropriate placement and adherence to the no reject/eject expectation. The Cabinet would expect the Agency to not reject or eject any child that meets the Agency's acceptance criteria. The child's level of intellectual functioning and level of aggressive or disruptive behavior shall not be used as a basis for rejecting or ejecting a child. In the event of a crisis, the Agency shall make every effort to maintain the child in their program. Examples of additional services that may be necessary to maintain the placement include the following: increased therapy, one-on-one mentoring from program staff, a specialized crisis response team, etc. If a child presents in acute psychiatric crisis and is a danger to self and/or others requiring acute inpatient psychiatric hospitalization, the Agency shall re-admit the child to their program following hospitalization. The Agency shall also re-admit the child in the event of an AWOL, and the Agency shall take measures to prevent future AWOLs.

Assessment, Treatment, and Permanence

As delineated in Attachment F of the PCC agreement, Agencies shall complete a standardized assessment to identify the child's needs and strengths while focusing on objectives that must be achieved and supports that are needed in order for the child to achieve permanency. Successful applicants shall conduct at least monthly a treatment team review of the child's and family's progress toward meeting each treatment goal.

Successful applicants shall describe how the Agency will work in partnership with Cabinet staff to prepare the child and family for reunification when there is a permanency goal of return to parent. The Agency shall be able to articulate its ability to accomplish each of the following tasks:

- Acknowledge each child and family's strengths and challenges and build treatment plans that optimize those strengths while simultaneously working to overcome the challenges;
- Assist the biological or adoptive family by helping them to develop the needed skills to help their child make a smooth transition home or to a less restrictive placement;
- Teach the biological or adoptive family methods/strategies that have been effective in treating the child so that they can use these skills on home visits and upon discharge; and
- Offer services, including family counseling and treatment team meetings, via telephone for those families who are unable to travel to the program.

Evidence Based Programming Continuum

As the Agency considers its response to this application, it is important to note that evidence based programming is key to a successful application. Evidence based programming should include, but not be limited to, a clear description of a model or intervention that has data and scientific support of its success. This application does not require the Agency to follow one (1) exact evidenced based model, as a complete model may not exist with

evidence. The successful applicant may use components of programming that follow evidence based models which have documented examples of success for the population the Agency plans to serve (i.e., Trauma Focused Therapy as an element of overall individual treatment planning). Therefore, the successful applicants shall specify a clearly defined proposed population and shall articulate the service parameters to be offered for that population as well as a description of the living environment where the population will reside.

Post-Discharge Services

Successful applicants are expected to facilitate the provision of three (3) month post-discharge services. Successful applicants shall incorporate discharge planning in all treatment plans from the time of initial placement. The treatment team shall determine what outcomes and resources must be in place for the child or youth's successful transition into less restrictive care or permanency. This transition planning shall begin at program entry and be reviewed on an ongoing basis to ascertain the feasibility of the discharge plan both for the child and the child's permanency goal(s). The treatment team shall discuss at regular intervals progress towards the discharge plan, making the child aware of his/her success. This process may include community resource linkages, parent or caregiver services, safety planning and general post discharge supports at a minimum. The rationale for such discharge services lies in the fact that if a child is released from high intensity services with no supports, successful transitions will be minimal and reentry more likely. In an effort to determine program efficacy, the Cabinet will require three (3) months of post-discharge services. Additionally, a brief follow up report shall be submitted at six (6) and nine (9) months post-discharge. These follow up reports shall entail a simple tracking of the child's overall safety, permanency, and well-being. The results demonstrated by the post-discharge outcomes will influence future programming decisions.

Successful applicants may consider innovative partnerships with other providers to address the post-discharge services portion of their model or other program components that will be enhanced through these identified partnerships. The Agency shall assist any child preparing for discharge by collaborating with other agencies in order to link the child to community resources such as community mental health centers (CMHCs); Impact Plus; psychiatric services; public school system, GED programs, or technical schools; support groups such as NA, AA, Al-Anon, etc.; and any other resource that the child may need in order to be successful upon discharge. In addition, the Agency shall prepare older children who will "age out" of the Cabinet's custody for discharge by assisting in securing community resources. This process should begin at least six (6) months prior to the anticipated discharge date.

Psychosocial

All individual and group therapy shall be conducted by a qualified mental health professional as defined in KRS 645.020. The Agency has the option of employing or contracting for these services.

Program Efficacy

Aggregate measures of success are also critical for a successful application. The Cabinet has attached basic permanency outcomes that are aligned with federal expectations. As the Agency considers its model, it shall include a plan to measure the child's overall movement in accordance with his/her individual treatment plan. The successful applicant will utilize measures/data directly from their selected evidence based model(s) and integrate those measures/data with the federal measures identified in the addendum. The Cabinet will work with successful

applicants to design a format that will report on both measures proposed by the provider and those required. The reporting will be tailored in part to the successful Agency's model.

Disclaimer

This request for applications may be canceled at any time and for any reason, or all applications rejected, if it is determined in writing that such action is in the best interest of the Cabinet. Receipt of application materials by the Cabinet or submission of an application to the Cabinet confers no rights upon the applicant nor obligates the Cabinet in any manner. The Cabinet may reject any proposal that is incomplete or in which there are significant inconsistencies or inaccuracies. The Cabinet reserves the right to reject all proposals.

This agreement is expressly conditioned on the availability of state and federal appropriated funds. The Cabinet shall fund the delivery of services and supports, and activities under the terms and conditions of this agreement to the extent that the funding allocations specified are made available to the Cabinet.

All items in this request for applications may be negotiated at the discretion of the Cabinet. For successful applicants, this provision of services will become an addendum to their PCC agreement.

Timeframes: (all dates are close of business EST)

11-5-10	Questions **submitted electronically** to the PCC/PCP Liaison
11-19-10	Electronic response to questions provided by DCBS
12-17-10	Applications **mailed/postmarked** to the PCC/PCP Liaison
3-4-11	Notification to successful applicants
4-15-11	Process for implementation finalized between DCBS and successful applicants

Julie Cubert, PCC/PCP Liaison
Department for Community Based Services
Quality Assurance and Policy Development Branch
275 East Main Street 3C-C
Frankfort, Kentucky 40621
Julie.Cubert@ky.gov

Application for Services for High Intensity Youth (5S)

Please note: An application is required for <u>each licensed location</u> that the Agency proposes to provide 5S services.

Name of organization: _____

Physical address: _____

Telephone number: _____

Agency contact for application: _____ Title: _____

E-mail address: _____

Signature: _____ Date: _____

List the number of placements for which the Agency is applying: _____

Provide a description for each of the items below:

General Programming

1) How the treatment unit(s) in residential care will be physically structured, e.g., specify whether the 5S children will reside in a separate cottage/wing or will be housed with other children. Please note that the Cabinet has set a minimum of ten (10) beds per treatment unit for residential care. Should an applicant propose to serve the children in therapeutic foster care setting, the minimum number of 5S children is six (6) per Agency with only one (1) foster child placed in a foster home.
2) The physical site in which children will live and receive services, specifying any accommodations, physical structures, or technologies that will assist in the treatment of this population. Please include where the children will receive educational services.
3) The proposed length of stay in the treatment program. The length of stay should be individualized based on the child's needs, but should reflect the tenets of the model being proposed.
4) The admission criteria and process for quick program entry.

Assessment, Treatment, and Permanence

5) The assessment process and the tools that will be utilized to complete the assessment. Provide three (3) examples of comprehensive assessments similar to those 5S children that the Agency anticipates serving.
6) How the initial assessment and initial individualized treatment plan (ITP) will address the child's transition to permanency and/or a less restrictive environment. Provide three (3) examples of initial assessments and ITPs similar to those 5S children that the Agency anticipates serving.
7) How the treatment planning process will be modified to address the identified specialized population. Individualized safety planning process for each child, addressing all identified issues from the assessment.
8) How permanency will be integrated into treatment. Give examples of the Agency currently works to achieve permanency, and provide data to support this.

9) Crisis/safety protocols, including risk to self, others, and victimization.
10) How the Agency will identify, then utilize child strengths to assist in the development of an individualized plan of needed supports.
11) The distinct services that will be provided, and describe how these services differ from those provided to other children in the same residential or therapeutic foster care program.

Post-Discharge Services

12) The child's treatment plan articulating needed resources for the child and implementation of post-discharge services. Include services to biological family, potential adoptive family, or permanent legal guardian.
13) "Unplanned and/or unfavorable" discharge criteria. Describe additional steps that will be taken to maintain placement stability before a child is discharged for any reason other than to a less restrictive placement.

Evidence Based Programming Continuum

14) The evidenced-base model(s) that the program will utilize to improve treatment and permanency outcomes. Fully describe the model and how it will be implemented in the Agency's program.
15) How the program will be structured, including daily activities that reflect appropriateness for the target population.
16) How the evidence based practices will be infused into daily treatment and activities.
17) The program's ability to follow the child throughout the treatment process including post-discharge services. Include a plan for tracking a child's overall safety, permanency, and well-being, as well as a plan for quarterly reporting on post-discharge services.
18) The treatment philosophy and practice. Include supports and whether those will be provided by the Agency or through community partners. Specify existing and anticipated working relationship(s) with community partners. Specify any contractual arrangements and/or MOUs for sharing information and treatment planning.
19) The plan for daily review of progress and need with attention to permanence and less restrictive services integrating external event changes when applicable
20) The plan to connect the child to the community during treatment.
21) The capacity to transition children to lower levels of care.

Psychosocial

22) The plan for medication management to include medication administration and oversight.
23) The plan for meeting children's mental health needs.
24) The plan for providing physical health services, dental care, and any other identified medical services.
25) The plan for providing or accessing services such as occupational therapy, physical therapy, speech therapy, etc.

Program Efficacy

26) The program model's measures of success. Describe how these measures will integrate/supplement with the Cabinet's identified measures (see Addendum).
27) The reporting process for the program's monthly progress with regards to the children's measures.
28) The plan for making records available to Cabinet staff for clinical reviews.
29) The plan for ongoing intra-Agency clinical quality assurance.
30) The staffing pattern to include staff-to-child ratios and credentials necessary to implement this model. The description should include any/all staff that will have contact with the children.

31) The plan for staff training/development.

Additional submission requirements:

32) Provide a copy of the Agency's most recent accreditation report. The Agency will be expected to submit any subsequent report to the Cabinet within thirty (30) days of any change in the report status.
33) For each partnership identified, the Agency shall submit letters of commitment or memorandums of understanding that clearly delineate the roles and responsibilities of the identified partner(s).
34) Provide a detailed budget, using the budget format submitted to DCBS for annual cost reports.

Addendum

Background on Federal Outcomes:
The Child and Family Services Review (CFSR) is the federal government's program for assessing the performance of State child welfare agencies with regard to achieving positive outcomes for children and families. It is authorized by the Social Security Amendments of 1994 requiring the U.S. Department of Health and Human Services (HHS) to promulgate regulations for reviews of State child and family services programs under titles IV-B and IV-E of the Social Security Act. The CFSR is implemented by the Children's Bureau of the Administration for Children and Families within the HHS.

The Kentucky CFSR was conducted the week of June 16, 2008. The period under review for the case reviews was from April 1, 2007 through June 20, 2008. Kentucky was required to develop and implement a Program Improvement Plan (PIP) to address each area that was not in substantial conformity with a particular outcome. PIPs are negotiated through a two (2) year implementation period, and PIP products are submitted quarterly. Kentucky submitted its proposed performance improvement plan in March 2010. The document was the culmination of a variety of efforts by regional CFSR/PIP/CFSP teams, central office program staff, the Community Stakeholders Advisory Group, members of the Court Improvement project, and the state's interagency partnership with mental health program personnel.

The Cabinet has identified the following outcomes and their underpinning items as areas where PCC/PCP providers can assist in meeting federal standards. Please note that the term "foster care" applies to any OOHC placement.

Permanency 1: Children have permanency and stability in their living situation
Item 6: Stability of foster care placements

Permanency 2: The continuity of family relationships and connections is preserved
Item 13: Visiting with parents and siblings in foster care
Item 14: Preserving connections
Item 16: Relationship of child in care with parents

Well Being 2: Children receive services to meet their educational needs
Item 21: Educational needs of child

Well Being 3: Children receive services to meet their physical and mental health needs
Item 23: Mental health of child

The attached chart lists outcomes as well as preset standards. **Complete the following chart to indicate how the program model plans to integrate the performance measures:**

Outcome/Item:	Standard:	Success Indicator:	Considerations:	Report/Source of data to support success indicator:

P1, Item 6: Stability of foster care placements	90 percent or higher In 67.5 percent of the applicable cases, reviewers determined that children experienced placement stability or that changes in placements were in the best interests of the child.			
P2, Item 13: Visiting with parents and siblings in foster care	90 percent In 57 percent of the cases, reviewers determined that the agency had made concerted efforts to ensure that visitation frequency and quality were sufficient to meet the needs of the child and family.			
P2, Item 14: Preserving connections	90 percent Reviewers determined that the agency had made concerted efforts to maintain the child's connections with extended family, culture, religion, community, and school in 84 percent			

	of the cases.			
P2, Item 16: Relationship of child in care with parents	90 percent or higher Reviewers determined that the agency had made concerted efforts to support the parent-child relationships of children in foster care in 59 percent of the cases.			
WB 2, Item 21: Educational needs of child	95 percent Reviewers determined that the agency had made diligent efforts to meet the educational needs of children in 87 percent of the applicable cases.			
WB 3, Item 23: Mental health of child	90 percent or higher Reviewers determined that the agency had made concerted efforts to address the mental health needs of children in 90 percent of the cases reviewed.			